GOODS and SERVICES – DETAILED DESCRIPTION AND ESTIMATE

Client Name: _____ Medicaid #: _____

Category	**Description**	**Grant Exclusions**	**Cost Estimate**
Environmental Modifications/Client safety			
Community Inclusion		Experimental or unacceptable treatments	
Educational/ Therapeutic Recreation		Purely recreational items without therapeutic value are not approved.	
Communications			
Quality of Life/Other:			
TOTAL			

Note: All goods and services described herein must be included on the approved Plan of Care.

Please list each item separate including cost. If one item is over $300 please provide 3 BIDS for item.

Program Administrator Signature & Date: _____

☐ **Approved** ☐ **Denied**